Baltimore City Health Department
Ryan White CARE Act, Title I
Quality Improvement Program (QIP)

SERVICE CATEGORY:
CLIENT ADVOCACY
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Prepared by:
Training Resources Network
Cheryl Nesbitt
Lori DeLorenzo, RN, MSN
Jeffrey A. Menzer, RN, ACRN
Susan Thorner, MA

Baltimore City Health Department
Ryan White Title I Office
Quality Improvement Program

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Introduction

The Baltimore City Health Department (BCHD) Title I Quality Improvement Program (QIP) began in FY 2001, the purpose of which is to ensure that people living with HIV/AIDS (PLWH/A) in the Greater Baltimore Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White CARE Act. The FY 2001 QIP initiative focused on adult/adolescent primary care and case management services, while FY 2002 focused on medically related care and care coordination. The following service categories were reviewed during FY 2002:

- Substance abuse treatment services
- Mental health services: adults
- Mental health services: children and adolescents
- Case management adherence
- Client advocacy
- Co-morbidity services

To assess the degree to which the Standards for Client Advocacy services (Standards of Care) as established by the Greater Baltimore HIV Health Services Planning Council (Planning Council) were adhered to across the EMA, baseline data was gathered and analyzed from all Title I vendors in the EMA funded to provide the services listed above. Information presented in this report focuses exclusively on Client Advocacy services.

Section 1. Methodology

Process

The one to three day QIP reviews were conducted at 100% of ten agencies providing Client Advocacy services. Data was collected through three avenues: 1) consumer surveys; 2) agency surveys; and 3) client chart abstraction.

Consumer Survey: The Consumer Survey was designed to be completed by the clients. As needed, the Consumer Interviewer completed the tool while posing the questions to the client. The tool focused on three primary areas: a) general information about the consumer; b) services received; and c) level of involvement with the agency. The questions emphasized the type of services provided and client's knowledge about their care rather than on their satisfaction with services. Information related to consumer surveys will be summarized in a separate report.

Agency Survey: Agency surveys were completed by 100% of the agencies providing Client Advocacy services. The tool is a self-report of how well the agency complies with the EMA Client Advocacy Standards of Care. No additional verification of information was undertaken. The contact person for the agency was responsible for completing the agency tool. Information related to the agency survey is presented in Section 5.

Client Chart Abstraction: The chart abstraction tool was designed to assess the vendors' adherence to the Standards of Care as established by the Baltimore Title I Planning Council. The tool, which was reviewed by BCHD and the Planning Council, was developed by a content expert with demonstrated expertise in the area of client advocacy and case management services. The tool contained items relating to the Standards of Care, client demographics and descriptive items relating to service provision. In addition, the tool included several items which assessed the collaboration with a client's Medicaid Managed Care Organization (MCO) case manager and advocacy provided

on behalf of a client regarding their MCO services. (See Appendix A for a copy of the client chart abstraction instrument.)

Time Frame

The review period focused on services provided in FY2001 (March 1, 2001 to February 28, 2002) for Title I clients. Based on the number of clients reported receiving Client Advocacy services during FY 2001, vendors were instructed to randomly select a specific number of client records who received services in the defined time frame. Recommendations for obtaining a random sample were provided. In addition, vendors were instructed to include approximately ten records that represent services initiated in FY 2001 and three to five closed records. From the vendor-selected records, the QIP reviewers selected a specified, smaller number of records to review for adherence to the Standards. For each chart reviewed, one survey instrument was completed.

The individuals conducting the QIP reviews had expertise in the service category being reviewed. Reviewers were trained in the QIP process, received written instructions for completion of the client chart abstraction instrument, participated in an orientation conference call, and were provided additional guidance as needed during the QIP review process. All completed client chart instruments were reviewed for completeness and consistency and responses were entered into a customized database for subsequent analysis.

Sample

A total of 306 Client Advocacy client records were reviewed at the ten agencies. The number of records reviewed per site ranged from 14 to 45, with an average of 30.6 records reviewed per site (Table 1). A total of 10.7% of all reported Title I client records were reviewed. The proportion of agency clients reviewed ranged from 5.0% to 100% of all reported Title I clients (Table 2).

Table 1. Client Advocacy agencies reviewed, dates of review and number of Client Advocacy client records reviewed

Agency Name	Dates of review	Number of records reviewed during QIP	% of QIP total
Maryland Community Kitchen	September 26, 2002	14	4.5%
Chase Brexton Health Services	October 7-9, 2002	24	4.8%
Park West Medical Center	October 15, 2002	36	11.7%
Bon Secours Health Systems	October 16-17, 2002	42	13.7%
UMD: Pediatrics	October 21, 2002	27	8.8%
HERO	October 28, 2002	27	8.8%
JHU: Adult	November 6, 2002	45	14.7%
Health Care for the Homeless	November 20-21, 2002	37	9.1%
Queene Anne County	December 2, 2002	9	2.9%
UMD: Adult	December 4-6, 2002	45	14.7%
TOTAL		**306**	**100%[1]**
Average		30.6	10%
Minimum		14	2.9%
Maximum		45	14.7%

[1] Note on all tables: Due to rounding, the total may not be equal to one hundred percent.

Table 2. Number of Client Advocacy clients and proportion of Client Advocacy Records reviewed

Agency Name	Reported # of Title I clients receiving Client Advocacy services	% of EMA total	% of agency's clients reviewed by QIP
Maryland Community Kitchen	14	0.5%	100%
Chase Brexton Health Services	197	6.9%	12.1%
Park West Medical Center	80	2.8%	45.0%
Bon Secours Health Systems	510	17.8%	8.2%
UMD: Pediatrics	122	4.2%	22.1%
HERO	170	5.9%	15.8%
JHU: Adult	773	27.1%	5.8%
Health Care for the Homeless	83	2.9%	44.5%
Queene Anne County	9	0.3%	100%
UMD: Adult	892	31.2%	5.0%
TOTAL	**2,850**	**100%**	**10.7%**
Average	285	10%	35.8%
Minimum	9	0.5%	5.0%
Maximum	773	27.1%	100%

Section 2. Client Demographics

Gender and Age

Of the population sampled, the majority of clients (55.6%) were male and 43.1% female (Table 3). The mean age of clients was 41.5 years, with men being older than women (Table 4).

Table 3. Gender distribution

Gender	n=306
Female	132 (43.1%)
Male	170 (55.6%)
Transgender	1 (<1%)
Not documented	1 (<1%)
Missing/Not abstracted	1 (<1%)

Table 4. Age distribution

Age	n=306
13 – 19 years	2 (<1%)
20 –29 years	30 (9.8%)
30 – 39 years	93 (30.4%)
40 – 49 years	128 (41.8%)
50 – 59 years	40 (13.1%)
60 – 69 years	5 (1.6%)
>70 years	0 (0%)
Not documented	8 (2.6%)
Mean age (n=298) Min 18.9 years Max 65.9 years	41.5 years
Mean age Male (n=167) Min 22.8 years Max 65.9 years	43.7 years
Mean age Female (n=130) Min 18.9 years Max 65.0 years	35.8 years

Race/Ethnicity

Eighty-five percent of the clients were African-American, and nearly 7% (6.9%)were White (Table 5). Of the men, 85% were African-American and 5% were White. Of the women, 88% were African-American and 9% were White (Table 6). Race and gender was not documented for 4.9% of the clients.

Table 5. Race/ethnicity distribution

Race/Ethnicity	n=306
African-American	261 (85.3%)
White	21 (6.9%)
Hispanic	2 (<1%)
American Indian/Alaska Native	3 (1.0%)
Asian/Pacific Islander	1 (<1%)
Carribean	2 (<1%)
Other	1 (<1%)
Not documented	6 (2.0%)
Missing/Not abstracted	9 (2.9%)

Table 6. Race/ethnicity distribution by gender

Race/Ethnicity	Male	Female	Transgender	Not doc/Missing	Total
African-American	144 (84.7%)	116 (87.9%)	1 (100%)	—	**261 (85.3%)**
White	9 (5.3%)	12 (9.1%)	—	—	**21 (6.9%)**
Hispanic	2 (1.2%)	—	—	—	**2 (<1%)**
American Indian/Alaska Native	1 (<1%)	2 (1.5%)	—	—	**3 (1.0%)**
Asian/Pacific Islander	1 (<1%)	—	—	—	**1 (<1%)**
Caribbean	1 (<1%)	1 (<1%)	—	—	**2 (<1%)**
Other	1 (<1%)	—	—	—	**1 (<1%)**
Not documented /Missing	11 (6.4%)	1 (<1%)	—	3 (100%)	**15 (4.9%)**
Total	**170 (100%)**	**132 (100%)**	**1 (100%)**	**3 (100%)**	**306 (100%)**

Note: In this table, Not documented and Missing/Not abstracted categories have been combined.

Risk Factor

Slightly more than one-quarter of clients (26.8%) had an injection drug use-related (IDU) risk factor, followed by heterosexual contact (22.5%) and IDU and heterosexual contact (11.1%). Risk factor was not documented for 19.3% of all clients (Table 7). Of the sample, 45.8% of men and 31.8% of women had IDU-related risk factors. Risk factor and gender was not documented for 27.2% of women, and 17% of men (Table 8).

Table 7. Risk factor distribution

Risk Factor	n=306
IDU	82 (26.8%)
Heterosexual	69 (22.5%)
IDU and Heterosexual	34 (11.1%)
MSM	29 (9.5%)
Undetermined/Unknown	13 (4.2%)
MSM and IDU	5 (1.6%)
Hemophilia/coagulation	4 (1.3%)
Other	2 (<1%)
Perinatal transmission	0 (0%)
Not documented	61 (19.3%)
Missing/Not abstracted	7 (2.3%)

Table 8. Risk factor distribution by gender

Risk Factor	Male	Female	Transgender	Not doc/Missing	Total
IDU	57 (33.5%)	25 (18.9%)	—	—	**82 (26.8%)**
Heterosexual	22 (12.9%)	47 (35.6%)	—	—	**69 (22.5%)**
IDU and Heterosexual	16 (9.4%)	17 (12.9%)	1 (100%)	—	**34 (11.1%)**
Undetermined/Unknown	8 (4.7%)	5 (3.8%)	—	—	**13 (4.2%)**
MSM and IDU	5 (2.9%)	—	—	—	**5 (1.6%)**
Hemophilia/ coagulation	2 (1.5%)	2 (1.2%)	—	—	**4 (1.3%)**
MSM	29 (17.1%)	—	—	—	**3 (1.0%)**
Other	2 (1.2%)	—	—	—	**2 (<1%)**
Perinatal transmission	—	—	—	—	**0 (0%)**
Not documented /Missing	29 (17%)	36 (27.2%)		3 (100%)	**68 (19.3%)**
Total	**170 (100%)**	**132 (100%)**	**1 (100%)**	**3 (100%)**	**306 (100%)**

Note: In this table, Not documented and Missing/Not abstracted categories have been combined.

Disease status and biological indicators

Of the population sampled, 33.7% of clients had an AIDS diagnosis (Table 9). Disease status was not documented for slightly more than 11% of the clients. A total of 238 clients (78%) had CD4 counts documented. Of those, 10% had a CD4 value <50/mm^3 while one-quarter (25.3%) had CD4 values greater than 500/mm^3. The mean CD4 value was 354.0/mm^3, with women having a higher mean CD4 than men.

A total of 226 (74%) clients had a viral load documented, with 23% documenting an undetectable viral load. During the review period, 60% of the clients were documented on HAART (n=182).

Table 9. Disease status, CD4 and viral load values, and treatment status

Disease Status	n=306
CDC-Defined AIDS	103 (33.7%)
HIV-infection	164 (53.6%)
Deceased	0 (0%)
Not documented	35 (11.4%)
Missing/Not abstracted	4 (1.3%)
CD4 Values	
Mean CD4 (n=238)	354.0/mm^3
Mean CD4 Male (n=132)	337.4/mm^3
Mean CD4 Female (n=103)	377.0/mm^3
CD4 Distribution	**n=238**
‹50/mm^3	24 (10.0%)
50 – 199/mm^3	50 (21.0%)
200 – 499/mm^3	104 (43.6%)
› 500/mm^3	60 (25.2%)
CD4 values were not documented for 66 (22.2%) and missing from 2 (‹1%) of all client records reviewed.	
Viral Load Distribution	**n=226**
Undetectable	53 (23.4%)
1 – 999 c/mL	32 (14.1%)
1000 – 6,999 c/mL	38 (16.8%)
7,000 -19,999 c/mL	18 (7.9%)
20,000 – 54,999 c/mL	37 (16.3%)
› 55,000 c/mL	48 (21.2%)
Viral load values were not documented for 81 (26.4%) of all client records reviewed.	
Treatment Status	**n=306**
% documented on HAART at any time during review period.	60%
Treatment status was not documented for 66 (21.5%) of all client records reviewed.	

Changes in biological indicators

In an effort to examine clinical and treatment outcomes, laboratory values (CD4 and viral load) and treatment information (HAART) were abstracted at two points during the review period. Of the 306 records reviewed, two CD4 values were documented for 131 (43%) clients and one CD4 value was documented for 107 (35%) records. No CD4 values were documented for 68 (22%) records.

Clients for whom there were two CD4 values had a mean count of 403/mm^3 at the first entry and a mean of 414/mm^3 at the second entry, representing a mean increase of 2.7%. Clients who were documented on HAART at any point during the review period (n=106) had a mean first value of 377/mm^3 and a mean second value of 401/mm^3. For these clients, a mean increase of 6.3% was noted. A mean decrease of 8.7% was noted for clients not on HAART (n=25) (Table 10).

Table 10. Mean CD4 changes for clients with two CD4 values

CD4 changes	1st mean CD4 value	2nd mean CD4 value	Mean change
All clients with 2 CD4 values	403.8/mm3	414.3/mm3	+2.7%
Clients on HAART (n=106)	377.8/mm3	401.4/mm3	+6.3%
Clients not on HAART (n=25)	514.0/mm3	469.2/mm3	- 8.7%

Insurance status

Insurance coverage was documented at the beginning or first entry of the review period and at the end or last entry of the review period. At the first entry, 35.3% of clients had Medicaid insurance, 20.9% had Maryland Pharmacy Assistance Program (MPAP) coverage and 11.8% had Maryland AIDS Drug Assistance Program (MDAP) coverage (Table 11).

Of those who did not have any form of insurance at the first entry (n=55), 52.7% had some form of insurance coverage at the second entry. Twenty-percent (20%) had obtained MPAP coverage; followed by Medicaid, 16.4%; and MADAP, 10.9%. Of the 108 clients who had Medicaid at the first entry, seven lost this coverage or became ineligible. Overall, 127 (41.5%) clients had Medicaid at one time during the review period. Documentation of insurance status was not contained in 8.5% of the reviewed records.

Table 11. Insurance status

Insurance status	First Entry
Medicaid	108
MPAP	64
No insurance	55
MADAP	36
Medicare	24
Private/Commercial	19
MPC	8
Veteran's Administration	5
Not documented	26
Missing/Not abstracted	2

Note: Multiple values documented.

Residence

The most frequent ZIP code of client residence was 21215, followed by 21217 and 21223. ZIP code was not documented for 11.8% of records, but Baltimore was noted as the city of residence. Neither ZIP code nor city of residence was documented in 2% of the records reviewed (Table 12).

Table 12. Residence

ZIP Code/City	#/% of total
Baltimore/ZIP code not documented in client record	36 (11.8%)
21215	32 (10.5%)
21217	26 (8.5%)
21223	25 (8.2%)

ZIP Code/City	#/% of total
21216	22 (7.2%)
21207	15 (4.9%)
21229	15 (4.9%)
21213	13 (4.2%)
21218	13 (4.2%)
21202	11 (3.6%)
21230	11 (3.6%)
21201	9 (2.9%)
21206	6 (2.0%)
21205	5 (1.6%)
21211	5 (1.6%)
21224	5 (1.6%)
21225	5 (1.6%)
21212	4 (1.3%)
21222	4 (1.3%)
21231	4 (1.3%)
21237	3 (1.0%)
21401	2 (0.7%)
21617	2 (0.7%)
21638	2 (0.7%)
20785	1 (0.3%)
21012	1 (0.3%)
21061	1 (0.3%)
21133	1 (0.3%)
21203	1 (0.3%)
21208	1 (0.3%)
21210	1 (0.3%)
21214	1 (0.3%)
21219	1 (0.3%)
21221	1 (0.3%)
21226	1 (0.3%)
21227	1 (0.3%)
21234	1 (0.3%)
21239	1 (0.3%)
21607	1 (0.3%)
21619	1 (0.3%)
21620	1 (0.3%)
21623	1 (0.3%)
21666	1 (0.3%)
Residence not documented in chart	6 (2.0%)
Missing; not abstracted	6 (2.0%)
Total	**306 (100%)**

Comparison with Baltimore City EMA prevalence data[2]

In comparison with reported Baltimore City EMA HIV/AIDS prevalence, the sample of records reviewed is comparable in terms of age and race/ethnicity distribution. Females represented a higher proportion of records reviewed compared to Baltimore City prevalence data; 43% vs. 37.3%, respectively.

[2] Baltimore City Health Department, HIV Disease Surveillance Program, "Baltimore City HIV/AIDS Epidemiological Profile", Third Quarter 2002. Prevalence data on September 30, 2001 as reported through September 30, 2002.

Table 13. Demographic comparison of client records reviewed with Baltimore City EMA prevalence

Population	Reviewed client records	Baltimore City HIV/AIDS prevalance
% African-American	85.3%	89.0%
% White	6.9%	9.9%
% Adult Male (›13 years)	55.6%	62.7%
% Adult Female (›13 years)	43.1%	37.3%
% Ages 30 – 39 years	30.4%	30%
% Ages 40 – 49 years	41.8%	42%
% Ages 50 – 59 years	13.1%	15.6%

HRSA reporting categories

Client demographics by HRSA reporting categories are reported below.

Table 14. Proportion of client records reviewed by HRSA reporting category

Population	Reviewed client records
0 – 12 months	0%
1 – 12 years	0%
13 – 24 years	4%
Women ›= 25 years	38.5%
African-American/Female	37%
African-American/Male	46%

Section 3. Client-level Assessment of Compliance with EMA Standards of Care

A. Consumer/Client Identification (Standard of Care 1.1)

The Standard of Care 1.1 focuses on the identification and screening of eligible clients. Eligibility is based on verification of HIV status, eligibility for Title I services and other criteria established by the vendor.

If a client is determined to be eligible for Client Advocacy services, the process is initiated and intake is completed. If the client is not eligible for service, the vendor is expected to make suitable referrals. Because these activities generally occur prior to the opening of a Client Advocacy record, documentation of referrals would not be captured if the client was deemed ineligible for service.

Of the 306 records reviewed, 108 (35%) clients had an initial intake or assessment completed during the review period.

B. Intake (Standard of Care 1.2)

Standard of Care 1.2 outlines a series of key activities related to the intake process; a process which should be completed within two visits. As part of the initial evaluation, the presenting problem, living situation, financial entitlement, health insurance and history of substance abuse and mental health illness are to be assessed (Standard 1.2a). Based on the intake data, a written action plan is developed by the Client Advocate in conjunction with the client (Standard 1.2b). Consent to share and discuss the action plan with appropriate service providers is to be documented (Standard 1.2c) and all agency forms are to be completed (Standard 1.2d). Table 15 outlines compliance with the various components of the initial intake process.

Table 15. Assessment of compliance with Standard of Care 1.2

<table>
<tr><th>EMA Standard</th><th colspan="2">Percent of reviewed charts meeting Standards</th></tr>
<tr><td>The intake phase should be completed within two visits for consumers/clients who will be receiving on-going services. [Standard 1.2]</td><td>45%</td><td>(n=108)</td></tr>
<tr><td>Initial assessment will cover the following topics:

<table><tr><th>Area assessed (n=62)</th><th>% completed</th></tr><tr><td>Living situation</td><td>94%</td></tr><tr><td>Financial entitlement</td><td>89%</td></tr><tr><td>Substance abuse</td><td>89%</td></tr><tr><td>Mental health history</td><td>89%</td></tr><tr><td>Health insurance</td><td>81%</td></tr><tr><td>Presenting problem</td><td>79%</td></tr></table>[Standard 1.2.a]
Only those charts with an assessment (62 of 108) were included in the table above.</td><td>57%</td><td>(n=108)</td></tr>
<tr><td>Written action plan developed with the consumer client. [Standard 1.2.b]</td><td>53%</td><td>(n=108)</td></tr>
<tr><td>Signed consent to discuss action plan, if appropriate, with other service providers' case managers and develop a collaborative relationship with those entities on behalf of the consumer/client. [Standard 1.2.c]</td><td>54%

51 charts were excluded from analysis. Only those charts with an action plan were included.</td><td>(n=57)</td></tr>
</table>

Completion of all agency intake forms and discussions with consumer/client regarding grievance, confidentiality, client rights, client responsibilities, and agency services.
[Standard 1.2.d]

Item discussed (n=108)	% documented
Grievance policy	19%
Confidentiality policy	31%
Client rights	20%
Client responsibilities	20%
Agency services	20%

Of the 108 clients who presented for an intake, **only 45%** (n=62) had their intake **completed within the specified two visits** (Standard 1.2) and **57% had an initial assessment completed** (Standard 1.2a). Of those with an intake assessment documented, 87% assessed each of the five areas outlined in the Standards.

For many agencies, the intake form used for case management services is also used for Client Advocacy services. As a result, many other areas were often included in the initial assessment. Table 16 outlines the frequency in which these areas were assessed.

Table 16. Additional areas assessed by Client Advocates during intake

Area (n=62)	% completed
Medical history	65%
Current medications	61%
Legal history/issues	61%
Family composition	61%
Transportation	60%
Social/community supports	60%
Current health status/symptoms	55%
Recent CD4	48%
Employment history	44%
Recent viral load	42%
Primary medical care provider history	42%
Current medical needs	31%
Child care needs	31%
Awareness of safer sex practices	31%
Nutrition	23%
Recreational/social activities	2%
Physical/sexual abuse history	0%

Of the 108 clients presenting for intake, written action plans were developed for 53% (n=57) clients (Standard 1.2.b). Seventy-nine percent (79%) of the action plans were signed by the Client Advocate. Only 35% of the plans were signed by the client. (Note: The Standards do not require either the Client Advocate or the client to sign the action plan.) Of those records with a written action plan, 96% contained defined goals, 25% contained time-phased objectives and 32% identified resources.

Slightly more than one-half (54%) of the records with action plans contained a signed consent to share and discuss the plan with other providers (Standard 1.2.c). Less than 25% of the reviewed records contained all of the intake forms and documented discussion of clients and responsibilities, confidentiality, grievance procedure and agency services (Standard 1.2.d).

C. Implementation of Action Plan (Standard of Care 1.3)

Standard of Care 1.3 outlines the responsibility of the Client Advocate to provide advice, referrals and other assistance to carry out the action plan. Services may be rendered through office visits, home visits and/or phone calls in order to obtain the services or information necessary to make referrals for service (Standard 1.3.a). The Client Advocate is expected to follow-up and if necessary, coordinate referrals to maintain continuity of care and intercede on behalf of the client as needed (Standards 1.3.b & 1.3.c). All contacts with or on behalf of the client must be documented (Standard 1.3.e)[3] Table 17 outlines compliance with implementation of the action plan.

Table 17. Client-level assessment of compliance with Standard of Care 1.3

EMA Standard	Percent of reviewed charts meeting Standards
The Client Advocate through office visits, home visits, phone calls proactively works with the consumer/client to obtain the services or information necessary to make referrals for services. [Standard 1.3.a]	

Method of client contact (n=306)	% documented
Office visits	85%
Telephone contact	30%
Home visits	9%
Correspondence	8%
Hospital visits	<1%

The Client Advocate follows-up and, if necessary, coordinates referrals to ensure a continuity of care. [Standard 1.3.b]	(n=306) 59% contained documented referrals 33% contained documented outcomes
The Client Advocate intercedes on behalf of the consumer/client with other agencies when necessary. [Standard 1.3.c]	(n=306) 54% contained documented contacts made on behalf of client.
The Client Advocate maintains documentation on all contacts with or on behalf of the consumer/client. [Standard 1.3.e]	(n=306) 89% contained documented contacts with client.

Office visits (85% of clients) followed by telephone contacts (30%) were the most common types of contact documented for the 306 clients (Table 17). Few clients received home or hospital visits. Correspondence to the client was also documented (Standard 1.3.a). Fifty-nine percent (59%) of the records contained documentation of referrals made, but only one-third of the records contained documentation of outcomes of these referrals (Standard 1.3.b). Documentation of contacts made on behalf of the client was noted in 54% of the records reviewed (Standard 1.3.c). Almost all of the records (89%) contained documentation of contacts with clients (Standard 1.3.e).

D. Monitoring of Action Plan (Standard 1.4)

Standard 1.4 focuses on monitoring the action plan and provision of service. At a minimum, the action plan should be reviewed with the client every six months (Standard 1.4.a). While the client is enrolled in service, the Client Advocate is responsible for monitoring the services provided and acting as

[3] There is no Client Advocacy Standard 1.3.d.

an advocate when necessary (Standard 1.4.b). Table 18 outlines compliance with monitoring of the action plan.

Table 18. Client-level assessment of compliance with Standard of Care 1.4

EMA Standard	Percent of reviewed charts meeting Standards
The Client Advocate reviews the action plan at least each six (6) months with the consumer/client. [Standard 1.4.a]	48% (n=162) *59% of the reviewed charts contained an action plan (n=181). Of these, 19 were excluded from analysis because services had been received for less than six months.*

Area updated	% of reviewed action plans	
% of reviewed action plans requiring updated goals and objectives	73%	(n=78)
% of action plans requiring updates which were appropriately updated	100%	(n=57)*
% of updated plans with client signature	54%	(n=78)
% of records with updated health care provider information	5%	(n=78)
% of records with updated health insurance information	59%	(n=78)
% of records with updated CD4 count	41%	(n=78)
% of records with updated viral load	17%	(n=78)
% of records with updated medications	19%	(n=78)

*43% of action plans were appropriately reviewed (n=78) according to Standard 1.4.a. Of these, 57 required updating (73%).

The Client Advocate monitors the services provided and acts as an advocate for the consumer/client when necessary. [Standard 1.4.b]	84%	(n=55)

Of the 306 records reviewed, 59% (n=181) contained a formal action plan. Of these, 162 clients received services for six months or more, thereby requiring a review of the action plan. **Less than one-half (48%) of these action plans were reviewed according to the time frame** specified in Standard 1.4.a (Table 18). Of the action plans which were reviewed, 73% needed to be updated based on the documentation in the client record. Of these, all of the action plans (100%) were updated, but only 54% of the updated action plans were signed by clients. Of the records which documented a reassessment, 5% contained updated health care provider information; 59% updated client's health insurance information; 41% updated CD4 values; 17% updated viral load values; and 19% updated medications.

Few of the reviewed records (18%) documented any difficulties in achieving the goals of the action plan. Of those which indicated difficulties (n=55), 84% contained written strategies for resolving these difficulties.

E. Closure (Standard 1.5)

Standard 1.5 outlines the key components of terminating services and closing the case file. Closure of the Client Advocacy case may occur for a number of reasons, including the request of the client, request of

the agency, relocation, or client death. Prior to closure, with the exception of death, the Client Advocate shall attempt to inform the client of the re-entry requirements and clearly delineate what it means to close the case (Standard 1.5.a). The agency is required to establish procedures for terminating services and closing case files. Such procedures must be followed when Client Advocacy services are terminated (Standard 1.5.b). Table 19 outlines compliance with Standards relating to closure of case files.

Table 19. Client-level assessment of compliance with Standard of Care 1.5

EMA Standard	Percent of reviewed charts meeting Standards	
Prior to closure (with the exception of death), the agency shall attempt to inform the consumer/client of the re-entry requirements into the system and make explicit what case closing means to the consumer/client. [Standard 1.5.a]	56%	(n=9)
The agency shall close a consumer/client's file according to the procedures established by the agency. [Standard 1.5.b]	89%	(n=9).

Of the 306 records reviewed, only 9 (3%) were closed during the review period. Of these, 56% of the records documented information provided to the client regarding re-entry requirements (Standard 1.5.a) and 89% of the case files were closed according to agency procedures (Standard 1.5.b).

The most frequently documented reason for closure was lack of client contact (n=5). The remaining records were closed at client request, transfer of services to another agency, and incarceration. None of closures were due to changes in insurance or eligibility and status.

Section 4. Client-level Client Advocacy Outcomes

The QIP process also sought to determine what benefits the clients received from their Client Advocacy services. Since one of the primary functions of Client Advocacy services is to meet identified unmet client needs, this outcome of Client Advocacy services was assessed in seven areas: 1) income assistance; 2) health insurance: 3) housing; 4) primary health care provider; 5) substance abuse treatment services; 6) emotional counseling; and 7) transportation/health care related.

Adapting a case management outcomes evaluation methodology described by Mitchell H. Katz, MD and colleagues[4], the client records were reviewed to determine whether the:

1. Client's needs assessment identified a need in seven areas;
2. Client's case plan contained a goal to meet this identified need;
3. Client's record contained documentation of activities (e.g., progress notes or updated case plan) to meet this goal; and
4. Identified need was met through the provision of Client Advocacy services.

Definitions of met and unmet need used for outcome analysis

Need	Definition of "Unmet "Need	Definition of "Met" Need
Income Assistance	✖ Being unemployed; and/or ✖ Not receiving any public assistance	✖ Being employed and/or ✖ Receiving some public assistance
Health Insurance	✖ Having no health insurance; and/or ✖ Having inadequate insurance to meet needs ✖ Experiencing difficulty obtaining referrals/assignment to HIV primary care and/or specialty providers from MCO	✖ Having a form of health insurance and/or ✖ Having insurance to meet unmet need ✖ Obtaining necessary referrals/assignment to HIV primary care and/or specialty providers from MCO
Housing	✖ Being unstably housed; ✖ Living in shelter, SRO, doubled-up; ✖ Living in situation other than one's own house, apt., supported living	✖ Being stably housed ✖ Living in one's own house, apt., supported living
Primary Health Care Provider	✖ Not being able to identify primary health care provider/agency for HIV and other health care needs	✖ Being able to identify a primary health care provider/agency for HIV and other health care needs; ✖ Being able to report current CD4 count, viral load, treatment regimen
Substance Abuse Treatment Services	✖ Self reported drug or alcohol use and/or dependence during period before intake; ✖ Use of illicit/prescription drugs known to cause dependence; ✖ Use of more drugs than intended; ✖ Present of emotional/psychiatric problem associated with drug use	✖ Having received professional substance abuse services or participating in a self-help group
Emotional Counseling	✖ Self-reported	✖ Having seen a mental health provider, attended a support group or seen a spiritual provider

[4] Katz, MH, et. al., "Effect of Case Management on Unmet Needs and Utilization of Medical Care and Medications among HIV-Infected Persons" Annals of Internal Medicine 2001;135:557-565.

Need	Definition of "Unmet "Need	Definition of "Met" Need
Transportation/ Health-care related	✖ Self-reported ✖ History of missing health care related appointments due to lack of transportation	✖ Having transportation needs met; enabling compliance with health care related appointments

For purposes of this outcomes review, records that contained a recent case plan as well as those which contained a case plan from the prior fiscal year were included in the sample size. A total of 208, 68% of total records, were included in this outcomes review.

Results

Housing was the most commonly identified unmet need (47%) followed closely by income assistance (43%) (Table 20). Of those in need of housing, 90% had a goal established and 91% documented activities undertaken to meet this need. By the end of the review period, 45% of the clients had this need met. For clients in need of income assistance, 66% of clients had this need met.

Transportation services were identified as a need for slightly more than one-quarter (27%) of the population reviewed. Of those, 88% had a goal established and 100% had this need met.

Surprisingly, only 18% of the population indicated substance abuse treatment services were needed. Of those, 74% had a goal established with 68% successfully meeting this need.

Only 10% of the sample was in need of a primary health care provider. A goal was established for 95% of the clients and activities were documented in 90% of the records reviewed. During the review period, 85% of those needing a primary care provider were linked to care. Table 20 provides a summary of the findings of this outcomes assessment.

Table 20. Client-level Client Advocacy outcomes

Note regarding tables: For each service area, the percent of records with an identified unmet need is listed. The three subsequent rows—goal established, activities documented, and need met—the percentages are based on the number of records with an identified unmet need.

Service Area	Discussion
Income Assistance % with unmet need: 43% % with goal established: 91% % with activities documented: 97% % with unmet need met: 66%	Income assistance was the second most frequently identified unmet need. Most of these clients had a goal established in their action plan and Client Advocacy activities documented relating to income assistance, 66% of clients had this need met during the review period.
Health Insurance % with unmet need: 38% % with goal established: 95% % with activities documented: 99% % with unmet need met: 64%	Two-thirds (64%) of clients had their need for health insurance met during the review period. Almost all had a goal established in their action plan and Client Advocacy activities documented.

Service Area	Discussion
Housing % with unmet need 47% % with goal established 90% % with activities documented 91% % with unmet need met 45%	Housing was the most frequency identified unmet need. Most of these clients had a goal established in their action plan and Client Advocacy activities documented relating to securing housing.45% had this need met during the review period. Obtaining housing is a lengthy and difficult, so this level of achievement is not surprising.
Primary Health Care Provider % with unmet need 10% % with goal established 95% % with activities documented 90% % with unmet need met 85%	Few of the clients had an identified need for a primary health care provider, and almost all had this unmet need met during the review period.
Substance Abuse Treatment Services % with unmet need 18% % with goal established 74% % with activities documented 89% % with unmet need met 68%	Only 18% had an unmet need for substance abuse treatment services, and of those, 74% had a goal established. Only 68% had their need met during the review period. Given the high rates of IDU-related transmission risk among the records reviewed as well as the prevalence of substance abuse in the Baltimore EMA, a higher rate of unmet need would be expected.
Emotional Counseling % with unmet need 21% % with goal established 72% % with activities documented 84% % with unmet need met 58%	Only 21% had an unmet need for emotional counseling, and similar with substance abuse treatment services, only 72% had a goal for this service established in their action plan. Of these clients, only 58% had this need met during the review period.
Transportation/Health-care related % with unmet need 27% % with goal established 88% % with activities documented 100% % with unmet need met 100%	Slightly more than one-quarter had an unmet need for transportation services related to their health care appointments. All of these clients had this need met during the review period. Client Advocates appear to be successful in linking their clients with this service.

Section 5. Agency-Level Assessment of Compliance with EMA Standards

As part of the QIP process, agencies providing Client Advocacy services were asked to complete a five page survey (See Appendix B for a copy of the agency instrument). The purpose of this survey was to document the self-reported compliance with the EMA's Standards for Client Advocacy pertaining to agency policies and procedures. All data presented is self-reported by the surveyed agencies and the QIP process did not verify the agencies' responses. All ten of the Client Advocacy agencies completed the agency instrument.

Table 21 lists the services directly offered by the agencies which provide Client Advocacy services and those provided through referral agreements. The ten agencies provide a large number of other services to clients and range from ambulatory health care to ancillary and supportive services, such as transportation and direct emergency assistance. The agencies also indicate having access to a wide array of services through referral agreements. Dental care, legal services buddy/companion and enriched life skills were more likely to be provided through referral than directly.

Table 21. Services provided directly by Client Advocacy agencies or through referral agreements.

Service category (n=10)	% which provide service directly	% with referral agreements
Case Management	90%	10%
Client Advocacy	100%	10%
Case Management Adherence	60%	0%
Ambulatory Health Care	80%	20%
Outreach	60%	20%
Transportation	80%	30%
Direct Emergency Assistance	80%	10%
Viral Load Testing	40%	30%
Mental Health Services	60%	30%
Substance Abuse Treatment	50%	50%
Counseling	60%	20%
Housing Assistance	50%	40%
Food/Nutrition	50%	30%
Dental Care	30%	60%
Co-morbidity Services	30%	10%
Legal Services	20%	40%
Buddy/Companion	10%	30%
Enriched Life Skills	0%	30%
Other: OB/GYN	10%	—
Other: Health Education	10%	—
Other: Ophthalmology	—	10%
Other: Pharmacy	—	10%

Standards of Care

A. Licensing (Standards of Care 2.0)

Standards of Care 2.0 focuses on licensure requirements of both agency and staff providing Client Advocacy services.

Table 22. Agency-level assessment of compliance with Standard of Care 2.0

EMA Standard	Percent of agencies reporting compliance with Standard	
The agency/organization [providing Client Advocacy services] will show evidence of being licensed by an appropriate body. [Standard 2.0.a]	90%	(n=10)
Where applicable, staff will have licenses that are current and appropriate for providing Client Advocacy services. [Standard 2.0.c]	90%	(n=10)
Supervisors of Client Advocates shall be licensed social workers or registered nurse case managers. [Standard 2.0.d]	70%	(n=10)

All but one of the agencies report that the agency and/or staff are appropriately licensed to provide the Client Advocacy services (Standards 2.0.a and 2.0.c). All but three (70%) report that the supervisors of Client Advocates are appropriately licensed (Standard 2.0.d) (Table 22).

B. Training and Supervision (Standards of Care 3.0)

Standards of Care 3.0 focuses on the training and supervision requirements for Client Advocates and Standard 3.0.a focuses on documentation of such supervision.

Table 23. Agency-level assessment of compliance with Standard of Care 3.0

EMA Standard	Percent of agencies reporting compliance with Standard	
The agency will maintain documentation that demonstrates that Client Advocates services [are] provided directly by, or under the supervision of, or in consultation with a licensed social worker and/or registered nurse case manager. [Standard 3.0.a]	80%	(n=10)
The agency will maintain documentation for each Client Advocate of in-service and/or specialized training given or taken on pertinent topics related to HIV/AIDS. (Standard 3.0.b]	70%	(n=10)
The agency will have policies that encourage and allow continuing education and professional development opportunities to be pursed on a regular basis. [Standard 3.0.c]	80%	(n=10)
The agency will create a system to regularly updates the staff resource information network of available services for people living with HIV/AIDS. [Standard 3.0.d]	90%	(n=10)

All but two of the agencies (80%) report that Client Advocate services are provided under supervision or consultation of a licensed social worker and/or registered nurse case manager (Table 23). Standards relating to training of the Client Advocate staff are not universally being met. Seven of the 10 agencies report that Client Advocates receive in-service or specialized training on topics related to HIV/AIDS (Standard 3.0.b), and that 8 have policies that encourage continuing education opportunities (Standard 3.0.c). All but one have a system to regularly update staff on resources available (Standard 3.0.d). Methods used to update staff include regularly scheduled in-services and staff meetings, e-mails to staff, word of mouth and informal sharing among staff and formalized reporting back from conferences attended by staff.

C. Consumer/Client Rights and Responsibilities (Standard 4.0)

Standard 4.0 requires agencies to have policies and procedures established that delineate client rights and responsibilities, confidentiality and grievance procedures. Copies of these policies should be provided to clients. The Standards also outlines guidelines for retention of client records. Table 24 depicts agency compliance with Standard 4.0.

Table 24. Agency-level assessment of compliance with Standard of Care 4.0

EMA Standard	Percent of agencies reporting compliance with Standard	
The agency shall have policies and procedures that protect the rights and outline the responsibilities of the consumer/clients and the agency. These policies and procedures include:		
A written agency policy on consumer/client confidentiality. [Standard 4.0.a]	100%	(n=10)
A statement signed by the consumer/client that states that existing policies and procedures regarding confidentiality, grievance, eligibility and services have been explained to the consumer/client. [Standard 4.0.b]	60%	(n=10)
Copies of eligibility criteria and services available should be given to each consumer/client requesting services. [Standard 4.0.b]	50%	(n=10)
A system for ensuring that case records are protected and secured. [Standard 4.0.c]	100%	(n=10)
A written, signed consent for the release of consumer/client information that pertains to establishing eligibility for agency services. [Standard 4.0.d]	100%	(n=10)
A written grievance procedure. [Standard 4.0.e]	100%	(n=10)
A statement of consumer/client rights as well as responsibilities or agency expectations of each consumer/client. [Standard 4.0.f]	100%	(n=10)
A statement that outlines process for both voluntary and involuntary disengagement from services. [Standard 4.0.g]	100%	(n=10)
Retention of records: In Maryland, adult (over 18) records will be kept for a minimum of ten (10) years after last entry. [Standard 1.5.b]	80%	(n=10)

Retention of records: For children (under 19) the records must be archived until the child reaches the age of 24 or six (6) years after death, if sooner. [Standard 1.5.b]	100% *5 agencies indicated that this requirement was not applicable and were excluded from analysis.*	(n=5)

While all vendors report having a written policy regarding client confidentiality (Standard 4.0.a), only 60% require clients to sign a statement indicating the policies and procedures have been explained to them (Standard 4.0.b) (Table 24). One-half of the agencies have implemented a policy to provide a copy of eligibility criteria and service availability to clients (Standard 4.0.b). All agencies report having policies relating security of records, consent for release of information, grievance, and consumer rights and responsibilities and disengagement of services (Standards 4.0.c-4.0.g).

All but three (70%) of the agencies report having written policies for closing client records. For most of these agencies, client records are to be closed if there has not been client contact within a specified period of time and that attempts to contact the client have not been successful. One agency states that it closes a client record only if the client's care is transferred to another agency. All but two agencies report maintaining closed records of adult clients as mandated by the State (Standard 1.5.b).

D. Quality Assurance (Standard 5.0)

Standards 5.0 requires a quality assurance plan be established to monitor the appropriateness and effectiveness of Client Advocacy services. The Standard outlines six areas that should be addressed by the plan (Standards 1.5.0a-1.5.0.f).

Table 25. Agency-level assessment of compliance with Standard of Care 5.0

EMA Standard	Percent of agencies reporting compliance with Standard	
The agency must have a quality assurance plan to monitor both appropriateness and effectiveness of client advocacy services. [Standard 5.0]	80%	(n=10)
This quality assurance plan, contained in the consumer/client case file, should include:		
The mutually established action plan. [Standard 5.0.a]	70%	(n=10)
A needs assessment with psychosocial needs described. [Standard 5.0.b]	70%	(n=10)
Documentation of the services delivered, referrals made, advocacy efforts initiated to address the needs as presented in the action plan. [Standard 5.0.c]	70%	(n=10)
Evidence that the plan was reviewed at least each six (6) months and when appropriate was modified according to the needs of the consumer/client. [Standard 5.0.d]	60%	(n=10)
Evidence of linking consumer/clients with the full range of benefits and/or entitlements, especially Ryan White services. [Standard 5.0.e]	70%	(n=10)

Of the 10 agencies, all but two (80%) report having a quality assurance plan in place (Standard 5.0). Of the six areas to be addressed in the quality assurance review, 60% to 70% of these areas are reported to

be incorporated in the agencies' plans (Standard 5.0.a-e). All but one (90%) of the agencies report having a process for clients to evaluate the agency, staff and services. All of these agencies utilize a client satisfaction survey—either agency's or the state AIDS Administration's survey—and in addition, 40% utilize a consumer panel or advisory board and 10% use focus groups to evaluate services.

Section 6. Service Delivery Issues Relating to Medicaid Managed Care

The Standards for Client Advocacy services were first originated and ratified in October 1998.[5] At that time, the service was designed to "focus on continuity of care and ensuring consumers have access to special HIV resources **not offered by other service providers**."[6] The Client Advocate activities were "directed toward **immediate problem-solving, not based upon establishing long-term relationships or on-going services**."[7] The services were targeted to HIV-infected persons who were enrolled in a managed care organization (MCO), received MCO case management services yet still had unmet HIV-related needs. These Standards were later revised[8]. These revised, and now current Standards eliminated the reference to "immediate problem-solving" activities and facilitating access to special HIV resources "not offered by other service providers".

In an effort to explore activities related to MCO case management, the data collection tool included several items which assessed the collaboration with a client's MCO case manager and the advocacy services provided on behalf of a client.

Intake activities relating to MCO

Of the 108 clients who received an intake during the review period, 40 (37%) were documented having Medicaid at time of intake for Client Advocacy services. During the intake process, Client Advocates documented the name of the MCO agency for 45% of clients and the name and of the client's MCO case manager for 10%. The telephone and fax number of the MCO case manager was noted in 7.5% and 5% of records reviewed, respectively (Table 26).

Table 26. MCO-related items documented for clients with Medicaid at time of intake

Item documented at intake (n=40)	%
Name of MCO	45%
Name of MCO case manager	10%
Telephone number of MCO case manager	7.5%
Fax number of MCO case manager	5%

Implementation and monitoring issues relating to MCO

During the review period, 127 clients (41.5%) had Medicaid. Of these, **some form of collaboration** between the Client Advocate and the MCO case manager was **noted in only 11%** of the client records reviewed. Telephone and written correspondence were the documented forms of contact. Approximately 16% of the records reviewed documented some form of difficulty with her/his MCO that necessitated intervention by the Client Advocate. Issues addressed by the Client Advocate included access to: primary care services, specialty services, medications, substance abuse treatment services, re-certification of MCO coverage, dental services and case management services.

Of note is the limited number of records that documented re-certification of MCO coverage. While re-certification is required at a minimum, once a year, only 16.5% of the records contained such documentation.

[5] Greater Baltimore HIV Health Services Planning Council (October 2000). Standards of Care for Health Services and Support Services. Standards of Care: Client Advocacy. Section 12, page 1.
[6] Ibid.
[7] Ibid.
[8] Greater Baltimore HIV Health Services Planning Council (posted August 2001 to www.baltimorepc.org). Standards of Care for Health Services and Support Services. Standards of Care: Client Advocacy. Section 11, page 1. Note: The date of revision is not indicated on these current Standards.

Section 7. Discussion

The QIP process provided a systematic review of compliance to the EMA's Standards of Care for 100% of Client Advocacy providers (n=10) receiving Title I funds during FY2001. A total of 306 records were reviewed, representing 10.7% of the reported Title I client advocacy clients served in the Baltimore EMA.

The following items have a higher rate of compliance with the Standards of Care:

- Of those records with completed intake assessments (n=62), most (85%) contained the five assessment areas outlined in the Standards and many contained other assessment areas outlined in the EMA Case Management Standards of Care.

- Three-quarters of the reviewed records had documented CD4 and viral load laboratory values. Clients who were on HAART and for whom two CD4 values were documented (n=106) experienced a mean increase of 6.3% of their CD4 count. Clients who were not documented on HAART (n=25) experienced a mean decrease of 8.7%.

- For clients who had an action plan developed, most (96%) contained defined goals and 79% were signed by the Client Advocate.

- Of the clients who had received services for six months or longer and needed to have the action plan updated, all were appropriately revised.

- Client office visits was the most frequently documented form of client contact (85%), followed by telephone contact (30%). Few clients received a home visit (9%). Documentation of contacts made on behalf of the client was noted in 89% of all records.

- While a small number of records documented difficulties achieving the goals of the action plan, 84% of those that did indicate such difficulties outlined strategies for resolution.

- An assessment of client-level Client Advocacy outcomes shows that the most common unmet needs are for housing and income assistance. The most frequently met needs include receiving transportation assistance, obtaining a primary health care provider, and receiving substance abuse treatment services, income assistance and health insurance. Housing was the most difficult need to meet.

- Of the 9 client records that were closed, 89% were closed according to agency procedures.

- Agencies providing Client Advocacy services also provide a wide range of services to clients, both directly and by referral, and almost all provide ambulatory health care, case management and transportation services.

- All agencies report having policies relating to client confidentiality, grievance and security of records and information.

A review of data from the QIP process identifies several areas where there is a lower rate of compliance with the Standards of Care. These most notable areas are discussed below and include:

1. Initial evaluation;
2. Development, use and reassessment of action plans;

3. Documentation of referrals and contacts;
4. Client eligibility and closure of records; and
5. Staff training and supervision.

In respect to initial evaluations, 43% of the clients who sought Client Advocacy services during the review period did not receive an initial assessment. Of those that did receive an assessment, only 53% had an action plan developed and 35% of these plans were signed by clients. While Client Advocates appear to routinely assess mental health and substance abuse needs, if a need for these services is identified, Client Advocates are less likely to establish an appropriate goal when developing an action plan, and less successful in assisting clients in obtaining these services.

Client consent to discuss the action plan with other providers was documented in 54% of the reviewed records.

Regardless of new or ongoing clients, action plans were not consistently developed and reassessed. Of all records reviewed (n=306), only 59% contained an action plan. Of those due for a six-month review, less than one-half of eligible action plans were reviewed and of these, only 54% of clients signed a revised reassessment.

The primary intent of Client Advocacy services is to ensure that consumers have access to special HIV resources. As such, documentation of referrals and contacts made on behalf of the client are an integral part of service provision. Slightly more than half (59%) of the records documented referrals with outcomes noted for only one-third (33%).

Only 3% of the reviewed client records (n=9) were closed during the review period. Seventy percent (70%) of the agencies report having written procedures for closure of client records; some of these include lack of client contact within a specified time frame. Client eligibility for services or criteria for closure are not explicitly stated in the Standards.

Universal adherence to the Standards relating to staff licensure, training and supervision (Standard 2.0 & 3.0) of Client Advocates were not reported. Seven of the 10 agencies did not have appropriate supervision for the Client Advocates and evidence of licensure was missing from one organization. Documentation of inservice training for Client Advocates was lacking from 30% of the agencies.

In respect to collaboration with MCO case managers, a significant number of clients were enrolled in Medicaid (41.5%), but collaboration was documented with only 11% of clients with MCO. Of the clients receiving an intake during the review period, 37% had Medicaid, and the name of the MCO was documented for only 45% of these clients, the name of the MCO case manager for 10% and contact information for 7.5%. While the current Standards do not explicitly outline an expectation of collaboration with MCO case managers for clients with Medicaid, Client Advocates and case managers are expected to play a significant advocacy role on behalf of their clients. Often, this involves interceding with the client's insurance provider. The reviewed records documented little of this type of advocacy.

Section 8. Recommendations

The primary recommendations for Client Advocacy services focus on three areas: 1) priority areas for quality improvement projects; 2) review and revision of the Standards of Care; and 3) development of quality indicators for Client Advocacy services.

Priority Areas for Quality Improvement Projects

As previously identified, the most notable issues related to the provision of Client Advocacy services focus on five main areas: 1) initial assessment; 2) development and reassessment of action plans; 3) documentation of referrals and outcomes; 4) client eligibility and closure of records; and 5) staff training and supervision. As the EMA and individual vendors identify quality improvement projects to undertake, these five areas can be incorporated into those projects.

Review and Revision of the Standards of Care

As currently outlined, the Standards of Care lack adequate detail in respect to eligibility, action plan development and monitoring and case closure. This lack of detail contributes to the issues that were noted in the chart review and discussed in Section 7.

As an initial step in the quality improvement process, it would be beneficial to review the Standards of Care of three service categories that are closely linked: Client Advocacy, Case Management, and Case Management Adherence. For each service category, the purpose and goal should be carefully assessed to minimize duplication and offer discrete services. As part of this process it would be helpful to determine the need for each service category and revise the Standards appropriately. It is especially important to define the type of service to be provided for each service category, i.e. immediate problem-solving vs. long-term relationship. Expectations related to collaboration with MCO case managers should also be clearly articulated and defined.

Within the currently published Standards, specific areas that should be addressed or enhanced include the following: 1) client eligibility; 2) levels of service; 3) comprehensiveness of intake assessment; 4) content of action plan; 5) implementing, monitoring and reviewing the action plan; and 6) specific criteria for case closure.

The Standards should also specify the client-level data providers should be expected to document not only as part of the client intake/initial assessment but also regularly update. These include:

- HIV-transmission risk
- CD4 value
- Viral load
- Current medications, including antiretroviral therapy
- Current primary medical care provider
- Other case manager/case management agency
- Insurance status

Additionally, it may be beneficial to expand the routine reporting requirements to include more client-specific utilization data that can be used to monitor trends.

Quality Indicators

As the Standards are revised, the incorporation of quality indicators is integral to the quality improvement process. By identifying the core indicators to track and trend, the expectations regarding service delivery are further clarified. Based on the review of the Standards and the data collected as part of the QIP review process, the recommended core quality indicators to track as part of Client Advocacy services are identified in Table 27. Target performance goals have also been identified in this table, but the actual goal should be finalized in conjunction with BCHD and the Planning Council.

Table 27. Recommended Quality Indicators for Client Advocacy Services

Quality Indicator [Reference to current Standards]	EMA Mean Performance[9]	Performance Goal
% of records which document assessment of client's emergency needs/crisis at time of client identification. [Standard 1.1.c]	NA	80%
% of client records which document an initial assessment. [Standard 1.2.a]	57%	90%
% of client records which document completion of a written action plan. [Standard 1.2.b]	53%	90%
% of completed written action plans which include client signature/date.	NA	90%
% of client records which document a review of the action plan every six months with the client. [Standard 1.4.a]	48%	85%
% of client records closed after loss of contact for more than six months.	NA	90%
% of client records which document in writing all referrals and outcomes.	59%--referrals 33%--outcomes	90% referrals 80% outcomes
% of client records which document monitoring and tracking of client's health insurance coverage and recertification requirements.	NA	70%

[9] Recommended quality indicators that were not assessed as part of the QIP review process are noted by "NA" in this table.

Appendices

- Appendix A. Client Chart Abstraction Instrument: Client Advocacy Services.
- Appendix B. Agency Survey: Client Advocacy Services.
- Appendix C. Standards of Care, Client Advocacy, ratified: October 1998; [revision date: not indicated]. Greater Baltimore HIV Health Services Planning Council. http://www.baltimorepc.org.
- Appendix D. Standards of Care, Client Advocacy, origination date: October 1998, ratified: October 1998. Greater Baltimore HIV Health Services Planning Council. [Previous Standards of Care].

BCHD Quality Improvement Project
Client Advocacy
Client Chart Abstraction Instrument

Section 1. Reviewer Information

Instructions: Complete the requested information.

1.1	Date of review	
1.2	Name of reviewer	
1.3	Client chart ID#	
1.4	Time start chart review	
1.5	Time end chart review	
1.6	Total time for chart review (hrs:min)	
1.7	Chart start date (Date of first entry in client chart)	
1.8	Chart end date (Date of last entry in client chart)	
1.9	Dates of services reviewed in chart	☐ 3/1/01 to 2/28/02 (Default) ___ / ___ / _____ to ___ / ___ / _____
1.10	Was chart **opened/client advocacy services initiated** during review period?	☐ Yes ☐ No; client advocacy services initiated prior to review period ☐ Not documented in chart
1.11	Was **chart closed/client terminated** from client advocacy services during review period?	☐ Yes ☐ No; client continued to receive client advocacy services throughout review period ☐ Not documented in chart

Section 2. Client Demographics

Instructions: Provide the requested information based on information contained in the client's chart.

2.1 Date of birth	___ / ___ / _____ ☐ Age on 2/28/02 if no dob in chart ____ ☐ Not documented in chart
2.2 Gender	☐ Male ☐ Female ☐ Transgender ☐ Not documented in chart
2.3 Race/Ethnicity	☐ White ☐ Black/African-American ☐ Hispanic/Latino/a ☐ Asian/Pacific Islander ☐ American Indian/Alaska Native ☐ African ☐ Caribbean ☐ Other: Specify: ☐ Not documented in chart
2.4 HIV risk factor *[Check all that apply]*	☐ Men who have sex with men (MSM) ☐ Injecting drug user (IDU) ☐ MSM and IDU ☐ Heterosexual contact ☐ Heterosexual contact and IDU ☐ Hemophilia/coagulation disease or receipt of blood products ☐ Undetermined/unknown, risk not reported ☐ Perinatal transmission ☐ Other: Specify: ☐ Not documented in chart
2.5 Zip code client residing in on 3/1/01 (or first entry In review period)	_____ City, if no zip code indicated: ☐ Not documented In chart

2.6.a	Client health insurance on 3/1/01 (or first entry in review period) *[Check all that apply]*	☐ None ☐ Medicaid ‹See list of Medicaid MCOs› ☐ CHIPS ☐ Maryland AIDS Drug Assistance Program ☐ Maryland Pharmacy Assistance Program ☐ Maryland Primary Care Program ☐ Medicare ☐ Private/Commercial ☐ Veteran's Administration ☐ Corrections ☐ Unknown [client reports not knowing] ☐ Other: Specify: ☐ Not documented in chart

List of Maryland's HealthChoice Medicaid MCOs

AMERICAID Community Care
Helix Family Choice
Jai Medical Systems
Maryland Physicians Care
Priority Partners
United HealthCare

2.6.b	Client health insurance on 2/28/02 (or last entry in review period) *[Check all that apply]*	☐ None ☐ Medicaid ‹See list of Medicaid MCOs› ☐ CHIPS ☐ Maryland AIDS Drug Assistance Program ☐ Maryland Pharmacy Assistance Program ☐ Maryland Primary Care Program ☐ Medicare ☐ Private/Commercial ☐ Veteran's Administration ☐ Corrections ☐ Unknown [client reports not knowing] ☐ Other: Specify: ☐ Not documented in chart

2.7.a	HIV-disease status on 3/1/01 (or first entry in review period)	☐ HIV-positive, not AIDS Date of dx: ___/___/ ____ ☐ Date not documented in chart ☐ CDC defined AIDS Date of dx: ___/___/ ____ ☐ Date not documented in chart ☐ Not documented in chart
2.7.b	HIV-disease status on 2/28/02 (or last entry in review period)	☐ Deceased Date of death: ___/___/ _____ ☐ Date not documented in chart ☐ HIV-positive, not AIDS Date of dx: ___/___/ _____ ☐ Date not documented in chart ☐ CDC defined AIDS Date of dx: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart

2.8.a	CD4/Viral Load 3/1/01 (or first entry in review period)	CD4 _____ cells/uL Date of test: ___/___/ _____ ☐ Date not documented in chart Viral load: _____ Date of test: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of lab report in chart ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Patient flow sheet in chart ☐ Other/Specify:
2.8.b	CD4/Viral Load 2/28/02 (or last entry in review period)	CD4 _____ cells/uL Date of test: ___/___/ _____ ☐ Date not documented in chart Viral load: _____ Date of test: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of lab report in chart ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Patient flow sheet in chart ☐ Other/Specify:
2.9.a	Client on HAART 3/1/01 (or first entry in review period)	☐ Yes ☐ No ☐ Treatment not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of medication sheet from medical provider ☐ List of medications maintained by case manager ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Other/Specify:
2.9.b	Client on HAART 2/28/02 (or last entry In review period)	☐ Yes ☐ No ☐ Treatment not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of medication sheet from medical provider ☐ List of medications maintained by case manager ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Other/Specify:

Section 3. Compliance with Client Advocacy Service Standards

Instructions: The client chart should be reviewed only for the period March 1, 2001 to February 28, 2002. Only those phases of client advocacy that occurred during this review period should be reviewed.

3.1 Phase 1: Consumer/Client identification

☐ Initial client contact with agency for client advocacy services was during review period (3/1/01-2/28/02)
▶ GO TO 3.1.a, below

☐ Initial client contact with agency for services was before 3/1/01
▶ GO TO 3.2, p. 6

3.1.a Why was client referred for client advocacy services?

☐ Client was previously receiving case management services; no longer eligible for these services because currently enrolled in MCO

▶ Was this case management provided?
- ☐ By this agency.
- ☐ By another agency.
- ☐ Chart does not provide this information.

▶ Is client?
- ☐ Maintaining previous case manager.
- ☐ Being assigned a new client advocate at this agency.
- ☐ Chart does not provide this information.

☐ Client was not previously receiving **any** client advocacy or case management services; has current MCO coverage and newly seeking client advocacy services

3.2 **Phase 2: Intake**

☐ Client completed intake during review period (3/1/01-2/28/02)
▶ GO TO 3.2.a, below

☐ Client completed intake before review period (3/1/01-2/28/02)
▶ GO TO 3.3, p. 8

3.2.a

a) Date of initial intake visit	b) Date of second intake visit	c) Date intake completed
☐ Chart does not provide this information.	☐ Chart does not provide this information.	☐ Chart does not provide this information.

	Review item	Documentation
3.2.b	The intake phase should be completed within two visits for clients who will be receiving on-going services. *[CA Standard1.2]*	☐ Yes, intake completed within 2 visits. ☐ No, intake was not completed within 2 visits. ☐ Chart does not provide information. ☐ This standard not applicable to this client's situation; specify: ☐ Client not receiving on-going services
3.2.c	The initial assessment will cover specified areas. *[CA Standard1.2a]*	☐ Yes, initial assessment completed. ☐ No, initial assessment was not completed. ☐ Chart does not provide information. ☐ This standard not applicable to this client's situation; specify: ☐ Client not receiving on-going services

▶ Check areas contained in assessment:

☐ Presenting problem
☐ Financial status/entitlement(s)
☐ Substance abuse history
☐ Current health status/symptoms
☐ Current medications
☐ Recent viral load
☐ Primary medical care provider history
☐ Nutrition
☐ Child care needs
☐ Legal history/issues
☐ Recreational/social activities
☐ Awareness of safer sex practices
☐ Living situation
☐ Health insurance
☐ Mental health history
☐ Medical history
☐ Recent CD4
☐ Current medical needs (access to care/ medications)
☐ Transportation
☐ Employment history
☐ Family composition
☐ Social/community supports
☐ Physical/sexual abuse history

3.2.d	Written action plan shall be developed with the client. *[CA Standard1.2b]*	☐ **Yes**, action plan completed. ▶ Does action plan contain? (check all that apply) ☐ Defined goals ☐ Time-phased objectives ☐ Identified resources ☐ Client signature ☐ Client advocate signature ☐ **No**, action plan was not completed.

3.2.e	Client will sign consent for client advocate to discuss action plan, if appropriate, with other service providers' case managers and to develop collaborative relationships with those entities on behalf of the client. *[CA Standard1.2c]*	☐ **Yes**, chart contains signed consent to discuss action plan. ☐ **No**, chart does not contain signed consent to discuss action plan.
3.2.f	Completion of all agency intake forms and discussions with consumer/client regarding grievance, confidentiality, client rights, client responsibilities, and agency services. *[CA Standard1.2d]*	Does the chart contain evidence of discussion with client regarding the following agencies policies? *(Check only if evidence is provided.)* ☐ Grievance ☐ Confidentiality ☐ Client rights ☐ Client responsibilities ☐ Agency services How is evidence provided? *(Check all that apply.)* ☐ Signed statement by client that policies have been explained ☐ Progress note by client advocate ☐ Other/Specify: ☐ Chart does not contain information
3.2.g	Does chart indicate that the client is receiving primary HIV-related care.	☐ Chart documents that client IS NOT receiving primary HIV care. ☐ Chart does not document name of provider/agency; but does indicate that client is receiving primary HIV-related care. ☐ Information not provided. ☐ Other/Specify:
3.2.h	Agency shall assist the client in identifying and making an appointment with a medical provider for those not already connected to a primary medical care provider.	☐ **Yes**, client assisted in obtaining medical appointment. ☐ **No**, client was not assisted in obtaining medical appointment. ☐ This standard not applicable to this client's situation; specify: ☐ Client already connected to primary medical care provider. ☐ Client declines assistance. ☐ Other: Specify:
3.2.i	Does chart indicate that client is currently enrolled in a Medicaid Managed Care Organization (MCO)?	☐ **Yes**, chart documents current MCO enrollment. ▶ Does chart contain? *(Check if in chart; check all that apply.)* ☐ MCO agency. ☐ Name of MCO case manager. ☐ Telephone number of MCO case manager. ☐ Fax number of MCO case manager. ☐ **No**, chart documents that client is not enrolled in MCO. ☐ Information not provided.

3.3	Phase 3:Implementation of action plan	▶ This section is to be completed for all clients
	Review item	**Documentation**
3.3.a	The Client Advocate provides advice, referrals and other assistance necessary to carry out the action plan. *[CA Standard 1.3]*	Based on review of the client's chart, does the chart include? ☐ Action plan ☐ Documentation of referrals made ☐ Documentation of outcomes of referrals made ☐ Documentation of services provided to client ☐ Documentation of contacts made on behalf of the client ☐ Documentation of contacts with client ▶ Check all methods of client contacts documented. ☐ office visits ☐ home visits ☐ telephone contact ☐ hospital visits ☐ Other/Specify:
3.3.b	Coordination with MCO case manager.	☐ Client does not have a MCO case manager, ▶ GO TO 3.4, p 9 ❶ Does the chart indicate collaboration/contact with the client's MCO case manager? ☐ **Yes**, collaboration/contact documented. ▶ Check all methods of contact documented. ☐ telephone contact ☐ face-to-face visits ☐ correspondence (fax, e-mail, letter) ☐ Other/Specify: ☐ **No**, collaboration/contact not documented. ❷ Based on your review of the chart, did the client experience difficulties with her/his MCO that necessitated client advocacy intervention? ☐ **Yes** ▶ Check all issues/needs addressed by client advocate. ☐ Access to primary care services. ☐ Access to specialty services. ☐ Access to medications. ☐ Access to durable medical equipment (DME). ☐ Access to home care. ☐ Access to hospitalization. ☐ Access to substance abuse treatment. ☐ Recertification of MCO eligibility. ☐ Other/Specify: ☐ **No**; client did not experience difficulties. ☐ Information not provided.

3.4	Phase 4: Monitoring of Action Plan	▸ This section is to be completed for all clients
	Review item	**Documentation**
3.4.a	Client Advocate reviews the action plan at least each six months with the consumer /client. *[CA Standard 1.4.a]*	▸ Does chart contain an action plan for the client? ☐ **No,** chart does not contain an action plan. ▸ GO TO: 3.4.b ☐ **Yes,** chart contains an action plan. ❶ Does chart contain documentation that action plan was reassessed at least every **six** months during the period of service provision? ☐ **Yes** ▸ CONTINUE ☐ **No** ▸ GO TO: Section 3.4b ☐ **Not applicable:** Client received services less than six months, so a reassessment was not indicated. ▸ GO TO: Section 3.4b ❷ Based on the documentation in the chart, should the eassessment of the action plan have lead to development of new goals/objectives/outcomes (regardless of time frame)? ☐ **Yes**, action plan content needed to be updated based on the documentation in the client chart. ▸ Was action plan? ☐ Reassessed and appropriately updated; new goals/objectives outcomes established as indicated. ☐ Reassessed, but not updated as indicated. ▸ Did client sign reassessment? ☐ **Yes**, reassessment signed by client. ☐ **No**, reassessment not signed by client. ☐ **No,** initial/previous action plan content was still appropriate. ❸ Was medical information updated? *(Check all items that were updated and/or re-verified.)* ☐ Health care provider ☐ Health insurance ☐ Most recent CD4 count ☐ Most recent viral load ☐ Medications

3.4.b	Continuation of health insurance coverage	During the review period, did the client advocate identify and/or address client's recertification for Medicaid? ☐ **Yes** (check all that apply) ☐ Expected eligibility recertification date identified and documented in the client chart. ☐ Client advocate provided direct assistance with recertification documented. ☐ **No.** Chart does not contain documentation relating to client's recertification for Medicaid.
3.4.c	The Client Advocate provides written documentation of any difficulties in achieving the action plan goals and provides written strategies for resolving these difficulties.	☐ **Yes**. Based on documentation in chart, there are difficulties in achieving the action plan: ☐ YES, chart contains written strategies/plans for resolving these difficulties. ☐ NO, chart does not contain documentation of written strategies/plans for resolving these difficulties . ☐ **No**. Based on documentation in chart, there are no difficulties in achieving the action plan. ☐ Information not provided.

3.5	Phase 5: Closure	▸ This section is to be completed for all clients
	Review item	**Documentation**
3.5.a	Continuing eligibility for Client Advocacy services	During the review period, was the client found to be no longer eligible for client advocacy services? ☐ **Yes,** client determined not to meet eligibility criteria. ▸ Was client advocacy case file closed? ☐ **Yes**, case file was closed. ▸ Continue to 3.5.b ☐ **No**, case file was not closed. ▸ GO TO: Section 4 ☐ **No,** client continued to meet eligibility criteria. ▸ GO TO: Section 4
3.5.b	Reason for closure	Check applicable reason for closure: ☐ Based on insurance, client no longer eligible for client advocacy services. ▸ GO TO: 3.5.c ☐ At the request of the client. ☐ Client terminated by agency from service. ☐ Lack of client contact. ☐ Due to client death. ☐ Client relocated out of service area. ☐ Client advocacy services transferred to another client advocacy agency. ☐ Reason for closure not documented. ☐ Other: specify

3.5.c	Closure due to change in insurance ▶ To be completed for those clients whose charts were closed because of change in insurance (item 3.5.b)	Was client referred to or transitioned to case management services? ☐ **Yes** ▶ Was service provided by same agency? ☐ Yes. ☐ No. ☐ Information not provided. ▶ Was service provided by same staff person? ☐ Yes. ☐ No. New staff person providing case management ☐ Information not provided. ☐ **No** ▶ Reason for lack of transition? ☐ Client not eligible for case management services. ☐ Client was offered referral/transition, but declined. ☐ Information not provided. ☐ Information regarding referral/transition activities not provided.
3.5.d	Prior to closure (with the exception of death), the agency shall attempt to inform the client of the re-entry requirements into the system, and make explicit what case closing means to the client. *[CA Standard 1.5a]*	☐ **Yes**, chart contains documentation that appropriate notification was provided. ☐ **No**, chart does not contain evidence that standard was met. ☐ Not applicable; client deceased; notification not required.
3.5.e	The agency shall close a client file according to the procedures established by the agency. *[CA Standard 1.5b]*	☐ **Yes**, chart contains evidence that standard was met. ☐ **No**, chart does not contain evidence that standard was met. ☐ Information not provided.

Section 4. Service Outcomes

Instructions:

This section should be completed only for clients who had an action plan during the review period. Reviewers are asked to determine:

A) whether an unmet need was identified during the intake/assessment in 7 areas (income assistance, health insurance, housing, primary health care provider, substance abuse treatment services, emotional counseling, and transportation), and, if the unmet need was identified, then determine;
B) whether a goal to meet this unmet need was established in the action plan;
C) whether the chart contains documentation relating to client advocacy activities performed to meet this unmet need; and
D) whether the unmet need was met.

▸ If the chart does not contain a client action plan, check here: ☐ ■ END OF CHART REVIEW

4.1 **Income Assistance** Definition of unmet need: • Being unemployed; and/or • Not receiving any public assistance (SSI, SSDI, TANF) Definition of met need: • Being employed; and/or • Receiving some public assistance (SSI, SSDI, TANF)	A. Was unmet need for income assistance identified in latest assessment? ☐ Yes ☐ No ▸ GO TO 4.2 ☐ No intake/assessment in chart ▸ GO TO 4.2 B. Was goal established in latest action plan to address need for income assistance? ☐ Yes ☐ No C. Is there documentation in chart relating to client advocacy activities performed to address the need for income assistance? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for income assistance met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.2 **Health insurance** Definition of unmet need: • Having no health insurance; and/or • Having inadequate insurance to meet needs (e.g., medications) • Experiencing difficulty obtaining referrals/assignment to HIV primary care and/or specialty providers from MCO Definition of met need: • Having a form of health insurance; and/or • Having insurance to meet unmet need (e.g., MADAP) • Obtaining necessary referrals/assignment to HIV primary care and/or specialty providers from MCO	A. Was unmet need for health insurance identified in latest assessment? ☐ Yes ☐ No ▶ GO TO 4.3 ☐ No intake/assessment in chart ▶ GO TO 4.3 B. Was goal established in latest action plan to address need for health insurance? ☐ Yes ☐ No C. Is there documentation in chart relating to client advocacy activities performed to address the need for health insurance? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for health insurance met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.3 **Housing** Definition of unmet need: • Being unstably housed; or • Living in shelter; SRO; doubled-up with friend/relative; hospital-nursing home-residential care facility and medically ready for discharge; or • Living in situation other than ones own house, apartment, supported living Definition of met need: • Being stably housed • Living in ones own house, apartment, supported living	A. Was unmet need for housing identified in latest assessment? ☐ Yes ☐ No ▶ GO TO 4.4 ☐ No intake/assessment in chart ▶ GO TO 4.4 B. Was goal established in latest action plan to address need for housing? ☐ Yes ☐ No ☐ No action plan in chart C. Is there documentation in chart relating to client advocacy activities performed to address the need for housing? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for housing met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.4 **Primary Health Care Provider** Definition of unmet need: • Not being able to Identify a primary health care provider/agency from whom the patient can receive routine, non-emergent care related to HIV disease and other health care needs Definition of met need: • Being able to Identify a primary health care provider/agency from whom the patient has received routine, non-emergent care related to HIV disease and other health care needs • Being able to report current CD4 count, viral load, treatment regimen	A. Was unmet need for a primary health care provider identified in latest assessment? ☐ Yes ☐ No ▶ GO TO 4.5 ☐ No intake/assessment in chart ▶ GO TO 4.5 B. Was goal established in latest action plan to address need for primary health care provider? ☐ Yes ☐ No ☐ No action plan in chart C. Is there documentation in chart relating to client advocacy activities performed to address the need for primary health care provider? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for primary health care provider met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.5 **Substance Abuse Treatment Services** Definition of unmet need: • Self reported drug and /or alcohol use and/or dependence during period before Intake • Use of Illicit drugs/prescription drugs known to cause dependence • Use of more drugs than intended • Presence of emotional/psychiatric problem associated with drug use Definition of met need • Having received professional substance abuse services or participating in a self-help group	A. Was unmet need for substance abuse treatment identified in latest assessment? ☐ Yes ☐ No ▶ GO TO 4.6 ☐ No intake/assessment in chart ▶ GO TO 4.6 B. Was goal established in latest action plan to address need for substance abuse treatment services? ☐ Yes ☐ No ☐ No action plan in chart C. Is there documentation in chart relating to client advocacy activities performed to address the need for substance abuse treatment services? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for substance abuse treatment services met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.6 **Emotional Counseling** Definition of unmet need: • Self reported. Definition of met need: • Having seen a mental health provider, attended a support group, or seen a spiritual provider.	A. Was unmet need for emotional counseling identified in latest assessment? ☐ Yes ☐ No ▶ GO TO 4.7 ☐ No intake/assessment in chart ▶ GO TO 4.7 B. Was goal established in latest action plan to address need for emotional counseling? ☐ Yes ☐ No ☐ No action plan in chart C. Is there documentation in chart relating to client advocacy activities performed to address the need for emotional counseling? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for emotional counseling met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.7 **Transportation/Health care-related** Definition of unmet need: • Self reported need for transportation to health care related appointments • History of missing health care related appointments due to lack of transportation to appointments Definition of met need: • Having transportation needs met; enabling compliance with health care related appointments.	A. Was unmet need for transportation/health care-related identified in latest assessment? ☐ Yes ☐ No ■ END OF CHART REVIEW ☐ No intake/assessment in chart ■ END OF CHART REVIEW B. Was goal established in most recent/latest action plan to address need for transportation/health care-related? ☐ Yes ☐ No ☐ No action plan in chart C. Is there documentation in chart relating to client advocacy activities performed to address the need for transportation/health care-related? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for transportation/health care-related met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

■ END OF CHART REVIEW

BCHD Quality Improvement Project
Client Advocacy
Agency Survey

- Agency Name:
- Address:
- Person completing form:
- Telephone:
- Fax:
- E-mail:

Please check all of the services that your agency **directly provided,** on-site during Title I fiscal year 2001 (March 1, 2001-February 28 , 2002). **Note**: Do not limit your responses only to services funded by Ryan White Care Act.

- ☐ Ambulatory Health Care
- ☐ Mental Health Services
- ☐ Outreach
- ☐ Substance Abuse Treatment
- ☐ Transportation
- ☐ Buddy/Companion
- ☐ Case Management
- ☐ Case Management Adherence
- ☐ Counseling
- ☐ Dental Care
- ☐ Direct Emergency Assistance
- ☐ Food/Nutrition
- ☐ Housing Assistance
- ☐ Legal Services
- ☐ Enriched Life Skills
- ☐ Co-morbidity Services
- ☐ Viral Load Testing
- ☐ Other/Specify:

Please check all of the services that your agency does not directly provide on-site, but have **established (written) referral agreements** with other agencies to provide these services to your clients during Title I fiscal year 2001 (March 1, 2001-February 28 , 2002). **Note**: Do not limit your responses only to services funded by Ryan White Care Act.

- ☐ Ambulatory Health Care
- ☐ Mental Health Services
- ☐ Outreach
- ☐ Substance Abuse Treatment
- ☐ Transportation
- ☐ Buddy/Companion
- ☐ Case Management
- ☐ Case Management Adherence
- ☐ Counseling
- ☐ Dental Care
- ☐ Direct Emergency Assistance
- ☐ Food/Nutrition
- ☐ Housing Assistance
- ☐ Legal Services
- ☐ Enriched Life Skills
- ☐ Co-morbidity Services
- ☐ Viral Load Testing
- ☐ Other/Specify:

Standards of Care

A. Licensing

1. Is the agency licensed by an appropriate body?

   ☐ Yes ☐ No

2. Where applicable, do staff have licenses that are current and appropriate for providing client advocacy services?

   ☐ Yes ☐ No

3. Are all supervisors of client advocates licensed social workers or registered nurse case managers?

   ☐ Yes ☐ No

B. Training and Supervision

4. Does the agency maintain documentation that demonstrates client advocate services are provided directly by, or under supervision of, or in consultation with a licensed social worker and/or registered nurse case manager?

   ☐ Yes ☐ No

5. Does the agency maintain documentation for each Client Advocate of all in-service and/or specialized training, given or taken, on pertinent topics related to HIV/AIDS?

   ☐ Yes ☐ No

6. Does the agency have written policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis?

   ☐ Yes ☐ No

7. Does the agency have a system that regularly updates the staff of available services for people living with HIV/AIDS?

   ☐ Yes ☐ No

   ▸ If Yes, describe the system.

C. Patient Rights and Confidentiality

8. Does the agency have written policies and procedures regarding:

☐ Yes	☐ No	Confidentiality
☐ Yes	☐ No	Grievance procedures
☐ Yes	☐ No	Release of information
☐ Yes	☐ No	System for ensuring case records are protected and secured
☐ Yes	☐ No	Client rights, responsibilities and agency expectations of each client
☐ Yes	☐ No	Voluntary and involuntary/disengagement from services

9. Are patients required to sign a statement indicating policies and procedures regarding confidentiality, grievance, eligibility and services were explained them?

   ☐ Yes ☐ No

10. Are copies of eligibility criteria and services available routinely given to each patient requesting services?

    ☐ Yes ☐ No

    ▸ If Yes, Identify the eligibility criteria.

D. Client Record Closure

11. Have written procedures for closing client records been established?

    ☐ Yes ☐ No

    ▸ If Yes, describe the procedures.

12. Are records for adult clients (over 18 years) kept for a minimum of 10 years after last record entry?

☐ Yes ☐ No

13. Are records for children clients (under 19 years) archived until the child reaches the age of 24 or six years after death, if sooner?

☐ Yes ☐ No

E. Quality Improvement

14. Does the agency have an on-going quality improvement/quality assurance program for client advocacy services that identifies areas for improvement and subsequent actions taken?

☐ Yes ☐ No

15. Does the quality improvement plan routinely review documentation regarding:

☐ Yes	☐ No	Mutually established action plan
☐ Yes	☐ No	Needs assessment, with psychosocial needs described
☐ Yes	☐ No	Services delivered, referrals made and advocacy efforts Initiated to address needs identified in action plan
☐ Yes	☐ No	Review of plan every six months, at a minimum, and modified as appropriate
☐ Yes	☐ No	Linking clients to benefits and/or entitlements
☐ Yes	☐ No	Linking clients to services not available through other providers

16. Does the agency have a process for clients to evaluate the agency, staff and services?

☐ Yes ☐ No

- If Yes, describe this process.

CATEGORY: CLIENT ADVOCACY

ratified October 1998

STANDARDS OF CARE

Client Advocacy services provide assessment of individual needs, advice and assistance obtaining medical, social, community, legal, financial and other needed services. Services focus on continuity of care and ensuring consumers have access to special HIV resources.

The following are minimum standards for the provision of Client Advocacy Services. Agencies and individuals may exceed these minimum standards.

The services are determined by the assessment that the Client Advocate makes in discussions with the consumer/client.

1.0 PRACTICE GUIDELINES

1.1 CONSUMER/CLIENT IDENTIFICATION

To determine if an individual is eligible for services by the pre-established criteria developed by the service provider.

a. The agency shall screen all individuals who call, walk-in or are referred for Client Advocacy services. Verification of HIV status and eligibility for the services are required.
b. The agency shall make suitable referrals for those individuals who are not appropriate for the Client Advocacy service.
c. The agency shall assess the individuals in crisis to determine the immediate interventions that are appropriate.
d. The agency may assign a Client Advocate to provide on-going services.

1.2 INTAKE

The intake phase should be completed within two visits for consumer/clients who will be receiving on- going services.

a. Initial assessment will cover the following topics:
    - Presenting Problem
    - Living situation
    - Financial entitlement
    - Health Insurance
    - Substance Abuse and Mental Health history
b. Written action plan developed with the consumer/client.
c. Signed consent to discuss action plan, if appropriate, with other service providers' case managers and develop a collaborative relationship with those entities on behalf of the consumer/client.
d. Completion of all agency intake forms and discussions with consumer/client regarding grievance, confidentiality, client rights, client responsibilities, and agency services.

1.3 IMPLEMENTATION OF ACTION PLAN

The Client Advocate provides advice, referrals and other assistance necessary to carry out the action plan.

a. The Client Advocate through office visits, home visits, phone calls proactively works with the consumer/client to obtain the services or information necessary to make referrals for services.
b. The Client Advocate follows-up and, if necessary, co-ordinates referrals to ensure a continuity of care.
c. The Client Advocate intercedes on behalf of the consumer/client with other agencies when necessary.
e. The Client Advocate maintains documentation on all contacts with or on behalf of the consumer/client.

1.4 MONITORING OF ACTION PLAN

a. The Client Advocate reviews the action plan at least each six (6) months with the consumer/client.
b. The Client Advocate monitors the services provided and acts as an advocate for the consumer/client when necessary.

1.5 CLOSURE

Closure of the case at the request of the client, at the request of the agency (provided that pre-established procedures are followed), or due to death.

a. Prior to closure (with the exception of death), the agency shall attempt to inform the consumer/client of the re-entry requirements into the system and make explicit what case closing means to the consumer/client.
b. The agency shall close a consumer/client's file according to the procedures established by the agency.
In Maryland, adult (over 18) records will be kept for a minimum of ten (10) years after last entry. For children (under 19) the record must be archived until the child reaches the age of 24 or six (6) years after death, if sooner.

2.0 LICENSING

a. The agency/organization will show evidence of being licensed by an appropriate body.
b. Licenses must be current and available.
c. Where applicable, staff will have licenses that are current and appropriate for providing Client Advocacy services.
d. Supervisors of Client Advocates shall be licensed social workers or registered nurse case managers.

3.0 TRAINING AND SUPERVISION

The agency will provide adequate training and supervision for all Client Advocates.

The agency will:

a. Maintain documentation that demonstrates that Client Advocates services were provided directly by, or under the supervision of, or in consultation with a licensed social worker and/or registered nurse case manager.
b. Maintain documentation for each Client Advocate of in-service and/or specialized training given or taken on pertinent topics related to HIV/AIDS.
c. Have policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis.

d. Create a system that regularly updates the staff resource information network of available services for people living with HIV/AIDS.

4.0 CONSUMER/CLIENT RIGHTS AND RESPONSIBILITIES

The agency shall have policies and procedures that protect the rights and outline the responsibilities of the consumer/clients and the agency.

These policies and procedures include:

a. A written agency policy on consumer/client confidentiality.
b. A statement signed by the consumer/client that states that existing policies and procedures regarding confidentiality, grievance, eligibility and services have been explained to the consumer/client. Copies of eligibility criteria and services available should be given to each consumer/client requesting services.
c. System for ensuring that case records are protected and secured.
d. A written, signed consent for the release of consumer/client information that pertains to establishing eligibility for agency services.
e. A written grievance procedure.
f. A statement of consumer/client rights as well as responsibilities or agency expectations of each consumer/client.
g. A statement that outlines process for both Voluntary and Involuntary Disengagement from services.

5.0 QUALITY ASSURANCE

The agency must have a quality assurance plan to monitor both appropriateness and effectiveness of Client Advocacy Services.

This quality assurance plan, contained in the consumer/client case file, should include:

a. The mutually established action plan.
b. A needs assessment with psychosocial needs described.
c. Documentation of the services delivered, referrals made, advocacy efforts initiated to address the needs as presented in the action plan..
d. Evidence that the plan was reviewed at least each six (6) months and when appropriate was modified according to the needs of the consumer/client.
e. Evidence of linking of consumer/clients with the full range of benefits and/or entitlements, especially Ryan White services.
f. Evidence of linking the consumer/client with needed services, that are not available through other providers.

Standards of Service: Client Advocacy

Origination date: October 1998, ratified: October1998

STANDARDS OF CARE

Client Advocacy services provide assessment of individual needs, advice and assistance obtaining medical, social, community, legal, financial and other needed services. Services focus on continuity of care and ensuring consumers have access to special HIV resources not offered by other service providers. Client Advocate activities are directed toward immediate problem solving, not based upon establishing long term relationships or on-going services.

The following are minimum standards for the provision of Client Advocacy Services. Agencies and individuals may exceed these minimum standards.

Consumer/clients may be referred for Client Advocacy services by Case Managers or through self-referral. When referrals are made by Case Managers, documentation of HIV status and financial eligibility for Ryan White services should be provided to the Client Advocate.

The services are determined by the assessment that the Client Advocate makes in discussions with the consumer/client and when appropriate through liaison with the Case Manager.

1.0 PRACTICE GUIDELINES

1.1 CONSUMER/CLIENT IDENTIFICATION

To determine if an individual is eligible for services by the pre-established criteria developed by the service provider.

a. The agency shall screen all individuals who call, walk-in or are referred for Client Advocacy services. Verification of HIV status and eligibility for the services are required.
b. The agency shall make suitable referrals for those individuals who are not appropriate for the Client Advocacy service.
c. The agency may assign a Client Advocate to provide services when the requested service(s) are not complex are task oriented and are short-term in duration.

1.2 INTAKE

An intake form should be completed for each consumer/client who will be receiving services.

a. The task oriented assessment will cover the following topics:
   Specific presenting problem(s) or service sought.
   Current Case Management services.
   Health Insurance (TEHMA, Medical Assistance, HealthChoice, Medicare, etc.)
   Living situation
   Financial entitlement
   Substance Abuse and Mental Health history

b. Written action plan, which describes; the concrete services requested, identifies any agency that provide the services, the plan for linking the consumer/client, and process for handing over the consumer/client for resolution of the issues. This plan will be developed with the consumer/client and where appropriate with the case manager.
c. Signed consent to discuss action plans, if appropriate, with other service providers' case managers and develop a collaborative relationship with those entities on behalf of the consumer/client.
d. When appropriate, completion of all agency intake forms and discussions with consumer/client regarding grievance, confidentiality, client rights, client responsibilities, and agency services.

1.3 IMPLEMENTATION OF ACTION PLAN

The Client Advocate provides advice, referrals and other assistance necessary to carry out the action plan.

a. The Client Advocate through office visits, home visits, and phone calls proactively works with the client to obtain the services or information necessary to make linkages for services.
b. The Client Advocate follows-up and, if necessary, co-ordinates referrals to ensure a continuity of care.
c. The Client Advocate intercedes on behalf of the consumer/client with other agencies when necessary.
d. The Client Advocate maintains documentation on all contacts with or on behalf of the consumer/client.
e. Upon notice that the consumer/client has begun with the new service agency, the Client Advocate notifies the case manager who made the original referral.

1.4 CLOSURES, RECORD RETENTION

Closure of the case occurs when the consumer/client begins receiving the requested services.

a. The agency shall close a consumer/client's file according to the procedures established by the agency.
b In Maryland, adult (over 18) records will be kept for a minimum of ten (10) years after last entry. For children (under 19) the record must be archived until the child reaches the age of 24 or six (6) years after death, if sooner.

2.0 LICENSING

a. The agency/organization will show evidence of being licensed by an appropriate body.
b. Licenses must be current and available.
c. Where applicable, staff will have licenses that are current and appropriate for providing Client Advocacy services.
d. Supervisors of Client Advocates shall be licensed social workers or registered nurse case managers or have a minimum of five (5) years of experience in providing direct HIV client services and at least two (2) years of supervisory experience.

3.0 TRAINING AND SUPERVISION

The agency will provide adequate training and supervision for all Client Advocates.

The agency will:

a. Maintain documentation that demonstrates that Client Advocates services are directly and regularly supervised as stated in 2.0 d.
b. Maintain documentation for: 1. Client Advocates of in-service and specialized training given or taken on pertinent topics related to HIV/AIDS. 2. Supervisors to have on-going supervisory and specialized training on HIV/AIDS issues.
c. Have policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis.
d. Create a system that regularly updates the staff resource information network of available services for people living with HIV/AIDS.

4.0 CONSUMER/CLIENT RIGHTS AND RESPONSIBILITIES

The agency shall have policies and procedures that protect the rights and outline the responsibilities of the consumer/clients and the agency.

These policies and procedures include:

a. A written agency policy on consumer/client confidentiality.
b. System for ensuring that case records are protected and secured.
c. A written, signed consent for the release of consumer/client information that pertains to establishing eligibility for agency services.
d. A written grievance procedure.
e. A statement of consumer/client rights as well as responsibilities or agency expectations of each consumer/client.
f. A statement that outlines process for Voluntary and Involuntary Disengagement from services.

5.0 QUALITY ASSURANCE

The agency must have a quality assurance plan to monitor both appropriateness and effectiveness of Client Advocacy Services.

This quality assurance plan, contained in the consumer/client case file, should include:

a. The mutually established action plan.
b. A task oriented assessment.
c. Documentation of the services delivered, referrals made, advocacy efforts initiated to address the specific issues as presented in the action plan.
d. Evidence of linking of consumer/clients with the requested services that are not available through other providers, especially Ryan White services.